Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SUMMIT REHAB CENTERS
C/O THE MORRIS LAW FIRM
702 S BECKLEY AVE
DALLAS TX 75203

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 20

MFDR Tracking Number
M4-06-4942-01

MFDR Date Received
April 4, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS 12/6/05, 12/9/05 (97140), 12/13/05 (97140), 12/14/05 (97140), 12/15/05 (95851 & 97140), 12/16/04 (97140), 12/19/05 (95833), 12/21/05, and 12/30/05: Services can not be considered global or incidental to any other on that date. DOS 11/1/05 through 12/1/05, 12/7/05, and 12/29/05: NO EOB was received to understand the carrier's position to hold payment for valid services to Injured Employee. DOS 12/6/05 (97012), 12/9/05 (97012), 12/13/05 (97012), 12/14/05 (97012), 12/15/05 (97012), and 12/6/05 (97012) [sic], 12/19/05, 12/21/05 (97012): All fee guidelines have been followed for these services."

Amount in Dispute: $5,388.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Responding Party request the MDR rule that the requesting Party is due no further or additional reimbursement."

Response Submitted by: Lewis & Backhaus, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2005 through December 30, 2005	Physical therapy services, office visits and muscle testing	$5,388.80	$368.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute filed on or after January 1, 2002.
2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services provided on or after September 1, 2002.

3. 28 Texas Administrative Code §134.600, effective March 15, 2004, sets out the preauthorization requirements.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. 100%.
   - 880-107 – Denied per Insurance: Pre-authorization was not requested. 100%.
   - 902-002 – In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration
   - 880-104 – Denied per insurance: Unnecessary treatment according to peer review, IME or other medical review. 100%.
   - W9 – Unnecessary medical treatment based on peer review. 100%.
   - 509-001 – Correct coding initiative bundle guidelines indicate this code is a mutually exclusive code, considered included in another code on the same day as code 97012.
   - 509 – Correct coding initiative bundle guidelines indicate this code is a comprehensive component of another code on the same day as 99213.
   - 509 – Correct coding initiative bundle guidelines indicate this code comprehensive component of another code on the same day as 96004.
   - 663 – Reimbursement has been calculated according to state fee schedule guidelines.
   - 97 – Payment included in the allowance for another service/procedure: 96004, 97012, 99213
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - 45 – Workers Compensation State Fee Schedule Adjustment.
   - 309 – Only one of each physical medicine modality will be allowed per day.
   - 855-13 – Payment denied – The service is included in the global value of another billed procedure.

Issues

1. Did the requestor obtain preauthorization for the physical therapy sessions rendered on November 11, 2005, November 14, 2005, November 15, 2005, November 16, 2005, November 17, 2005, November 18, 2005, November 21, 2005, November 22, 2005, November 23, 2005, November 28, 2005, November 29, 2005, November 30, 2005, and December 29, 2005?
2. Did the requestor resolve the medical necessity issues per 28 Texas Administrative Code §133.308?
3. Did the requestor bill services that are bundled into other services rendered on the same day?
4. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 "(h)The non-emergency health care requiring preauthorization includes: (10)rehabilitation programs to include: (A)outpatient medical rehabilitation..." Review of the documentation finds:
   - The requestor submitted a preauthorization letter dated December 1, 2005, authorizing 10 visits of physiotherapy, specifically CPT codes 97110, 97112 and (97750-FC).
   - The requestor billed for physiotherapy (outpatient medical rehabilitation services) on November 11, 2005, November 14, 2005, November 15, 2005, November 16, 2005, November 17, 2005, November 18, 2005, November 21, 2005, November 22, 2005, November 23, 2005, November 28, 2005, November 29, 2005, November 30, 2005, and December 29, 2005.
   - The insurance carrier audited the charges and denied the charges with denial reason code "880-107 – Denied per insurance: pre-authorization was not requested. 100%."
   - The requestor did not submit documentation to support that preauthorization was obtained as required by 28 Texas Administrative Code §134.600(h), for the dates of service indicated above. Therefore, reimbursement cannot be recommended for these dates of service.

2. Per 28 Texas Administrative Code §133.307 "(a) Applicability. This rule applies to a request for medical fee dispute resolution for which the initial dispute resolution request was filed on or after January 1, 2002. Dispute resolution requests filed prior to January 1, 2002 shall be resolved in accordance with the rules in effect at the time the request was filed. In resolving disputes over the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the commission is to adjudicate the payment, given the relevant statutory provisions and commission rules. Medical necessity is not an issue in a medical fee dispute." Review of the documentation finds:
    - The insurance carrier denied CPT codes 97012, 97116, 97140, 99213, and G0283 rendered on December 1, 2005 with denial reason"880-140-Denied per insurance: Unnecessary medical treatment based on peer review.100%."
    - The insurance carrier denied CPT codes 97012, 97116, 97140, 99213, and G0280 rendered on December 7, 2005 with denial reason "880-140-Denied per insurance: Unnecessary medical treatment based on peer review.100%."
    - The proper venue to resolving a dispute of medical necessity is the IRO process 28 Texas Administrative Code §133.308. Therefore, the disputed charges with denial reason code "880-140" cannot be included in this audit.
3. Per 28 Texas Administrative Code §134.202, "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used." Review of the documentation finds:
    - The insurance carrier denied CPT code 97110 rendered on December 1, 2005 and December 7, 2005 with denial reason"880-140-Denied per insurance: Unnecessary medical treatment based on peer review.100%."
    - CPT code 97110 rendered on dates of service December 1, 2005 and December 7, 2005 were preauthorized by the insurance carrier under preauthorization # 40284, therefore the requestor is entitled to reimbursement.
    - The requestor submitted documentation to support that the services rendered were billed for date of service December 1, 2005. CPT code 97110 is reimbursement at 15 minute increments. The requestor billed and documented 3 units, therefore reimbursement is recommended as follows: $28.91 x 125% = $36.14, $36.14 x 3 = $108.42.
    - The requestor submitted documentation to support that the services rendered were billed for date of service December 7, 2005. CPT code 97110 is reimbursement at 15 minute increments. The requestor billed and documented 3 units, therefore reimbursement is recommended as follows: $28.91 x 125% = $36.14, $36.14 x 3 = $108.42.
    - The requestor billed CPT code 97012, 2 units (15 minutes/unit) on December 6, 2005, December 9, 2005, December 13, 2005, December 14, 2005, December 15, 2005, December 16, 2005, December 19, 2005, and December 21, 2005.
    - The insurance carrier reimbursed the requestor one unit of CPT code 97012. The requestor is therefore entitled to additional reimbursement of for one unit per date of service indicated above.
    - Medicare fee schedule amount is $15.21 x 125% = $ 19.01/unit. The requestor is entitled to one additional unit per date of service, 8 units x 19.01 = $152.08.
4. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine if edit conflicts exists for dates of service December 6, 2005, December 9, 2005, December 13, 2005, December 14, 2005, December 15, 2005, December 16, 2005, December 19, 2005, December 21, 2005, and December 30, 2005. The following CCI edit conflicts were identified:
    - Date of service December 6, 2005, December 15, 2005, procedure 99213 and component procedure 95851 are unbundled. A modifier is not allowed. Therefore reimbursement cannot be recommended for CPT code 95851.
    - Date of service December 6, 2005, procedure 96004 and component procedure 97116 are unbundled. The Standard Policy Statement reads "Misuse of column two codes with column one code." Therefore reimbursement cannot be recommended for CPT code 97116.

- Date of service December 6, 2005, December 9, 2005, December 13, 2005, December 14, 2005, December 15, 2005, December 16, 2005, December 21, 2005, and December 30, 2005, procedure 97012 and component procedure 97140 are unbundled. The Standard Policy Statement reads “Mutually exclusive procedure.” Therefore reimbursement cannot be recommended for CPT code 97140.
- Date of service December 19, 2005, procedure 99213 and component procedure 95833 are unbundled. A modifier is not allowed. Therefore reimbursement cannot be recommended for CPT code 95833.
- Date of service December 30, 2005, Procedure 97530 and component procedure 97116 are unbundled. The Standard Policy Statement reads "More extensive procedure". The use of an appropriate modifier may be allowed. Therefore reimbursement cannot be recommended for CPT code 97116.
- Date of service December 30, 2005, Procedure 97140 and component procedure 97530 are unbundled. The Standard Policy Statement reads "Mutually exclusive procedures". Therefore reimbursement cannot be recommended for CPT code 97530.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $368.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $$368.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March 7, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.